CLIENT DOGMATISM, THERAPIST LEADERSHIP AND THE PSYCHOTHERAPEUTIC RELATIONSHIP

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A DISSERTATION PRESENTED TO THE GRADUATE COUNCIL OF
THE UNIVERSITY OF FLORIDA
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE
DEGREE OF DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA
1969

ACKNOWLEDGEMENTS

The author wishes to thank the members of his supervisory committee, without whose patient help this dissertation would not have been possible. In particular, he wishes to thank the chairman, Dr. Audrey S. Schumacher, for her many hours of guidance and consultation. He is also indebted to Drs. Harry Grater, Jacquelin Goldman, Madelaine Carey, and William Purkey, all of whom have proven invaluable not only in the preparation of this dissertation, but in the author's graduate training at the University of Florida.

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INTRODUCTION

The psychotherapeutic relationship, as referred to in this paper, consists of the highly personal interaction between two people who have been brought together specifically to aid and enhance one of them. In the process of being together and discussing very personal and meaningful things, they may come to affect each other's behavior--they become for each other significant stimuli, eliciting from each other behaviors that hopefully will become predictable and controllable. The primary focus of therapy is the behavioral changes demonstrated by the person seeking help, but since these changes derive from occurrences within the context of the relationship, they cannot be understood or controlled without due regard for the behavior of the other member of the therapeutic encounter. Consequently, a recent trend in psychotherapy research has been to avoid the isolated study of techniques, diagnostic categories and particular problems, and to move toward multifactor experiments which can simultaneously examine various combinations within the context of the relationship.

This general conception of the therapeutic encounter is analogous to the statistical notion of <u>interaction</u>.

This notion recognizes that certain main effects may contribute significantly to the end result, but that when these effects occur in combination, prediction of the result depends upon close examination of the combinatory effects. In a therapeutic encounter, the factors are people, and the interaction suggests that the result of the relationship will depend upon the unique effects of therapist X and client Y on each other, in addition to whatever contributions the therapist's orientation and personality, and the client's problem and diagnosis might make.

As already mentioned, the client brings to the therapeutic encounter his need to be helped. Traditionally, the therapist also brings specific attributes to the meeting. Among recognized therapists, Carl Rogers (1957) has defined these attributes as simply as anyone--he has said that the therapist must be congruent, must have positive regard for the client, and be able to communicate these to the client. Most often there are additional requirements made on the therapist in the form of special training, supervised experience and, in some cases, certification. The effect of this combination of one seeking help with another who, by definition is highly qualified to offer help, invariably results in the therapist being cast in the role of authority figure. As with all elements of the relationship, this affects both parties in somewhat

different ways. The therapist, in accordance with his own personality and orientation to therapy, will handle his role as authority in various ways. In this, he will also be affected by his client, who brings to the situation a life style which includes certain basic and patterned ways of relating to authority and its representatives. Thus this most pervasive element of the relationship becomes fundamental to its successful resolution, and also provides valuable clues as to where to begin an investigation of the important components of the relationship itself.

Before continuing, it will be valuable to examine some of the precedents set by others in their study of psychotherapeutic relationships. Actually, the emphasis on relationship research is relatively new. In 1949 Seeman studied the reactions of clients who had been counseled by directive and non-directive techniques, and found significant differences in the reactions of counselees counseled by the same techniques, and non-significant differences among those counseled by different techniques. He concluded that something besides therapeutic method was leading to the different reactions among the clients. Fiedler (1950a, 1951a, 1953) maintained, and provided data to support the view, that it was the relationship between the therapist and the client, and not the methods, that led to successful therapy. However, he also pointed out (1953) that the method used might make a particular therapist more comfortable, and

thereby indirectly affect the outcome of the therapy. At the same time (1950b) Fiedler presented data to support the notion that theoretical orientation was not an especially relevant variable, although this too might presumably affect the outcome by making the therapist more or less comfortable in the relationship.

Rogers (1957) discusses what he feels are the major aspects of the good relationship. In terms of the interaction per se, he emphasizes the importance of the therapist experiencing unconditional positive regard and empathic understanding of the client, and also being able to communicate this to him. It will be noted that Rogers focuses on the role of the therapist, whom he sees as a constant in the situation, and does not discuss the role of the client in affecting the therapist's behavior. Truax (1966) has questioned the constancy of the Rogerian therapist, and shown that Rogers himself reacts differentially to client behaviors in therapy.

Somewhat later however, Rogers (1965) acknowledges the client as an elicitor of behaviors in the therapist, which is much closer to the point of view taken here. After reviewing some of the Rogerian-oriented studies on relationship, he concludes:

> Without trying to go further into this very complex research, I will simply say that it indicates that the attitudinal qualities I have described are provided

> largely by the therapist, but elicited partly by certain characteristics in the patient. Thus therapy is an interactional event. (p. 104)

As advanced experimental designs become more widespread, research in the area of therapy relationships has become more sophisticated. Recently, for instance, Lorr (1965) has used factor analysis on a collection of client perceptions of therapy and arrived at five therapist-behavior dimensions: accepting, understanding, authoritarian, independence-encouraging and critical-hostile. These findings provide clues as to the major ways in which therapists enter into the relationship, and how they are seen by the client. It is noteworthy for the point of view expressed above that one of the five basic perceptions that Lorr's clients reported having about the therapist's behavior was the authoritarian dimension. It lends empirical support to the universality and importance of this aspect of the relationship.

Recently Moos and Clemes (1967) have simultaneously studied several therapist and client behaviors in a multivariate design. They found, in support of the theoretical import of the present research, that both therapist and client behaviors are determined by the therapist, the client, and the particular therapist by client interaction. In their study they used five objectively defined behaviors: total word count, percentage of feeling words emitted, percentage

of action words, the number of questions asked, and the number of "Mm-hmms" emitted. A number of surprising findings came out of their data, including the fact that for at least one of their behaviors, the effect of the client upon the therapist was greater than the effect the therapist had upon the client! While potentially embarrassing, such a finding is consistent with the interactionary model proposed here, and points up the need for further research to determine what reciprocal effects the therapeutic participants have upon each other. Further, since no outcome data are reported, it cannot be known from this study what ultimate beneficial effects the therapist's "versatility" may have had on the client.

As mentioned above, the concept of authority is an integral and important element in the psychotherapeutic relationship, and, as such, it plays a central role in the present study. In keeping with the notion of relationship already developed in the preceding pages, the concept of authority will be examined within the context of the total interacting unit--the client and the therapist together. The best reflection of the therapist's reaction to his authoritarian role is the degree to which he exerts control or leadership in the relationship. An analogue of this for the client is his assertiveness or submissiveness in therapy, as well as his general orientation to authority and typical ways of responding to it. Several measures are

available to tap the latter--a measure of general authoritarianism or dogmatism has been chosen for this research.

The degree to which any therapist exerts leadership during the course of therapy depends upon his personality, including the important effects of his training and experiences, and on the particular client he is seeing at the moment. This assertion grows out of the theoretical conception presented here of the therapeutic relationship, and can be empirically tested. The ultimate therapeutic effects of leadership with different clients can also be tested. Both these questions, along with the effects of therapist leadership on the client during the course of the therapeutic encounter, will be examined presently.

It should be pointed out that the interactionary model proposed applies only to those cases where a free and spontaneous development of the relationship is fostered. This precludes a technique-oriented or role-playing stance on the part of the therapist if his techniques or roles are to be artificially imposed or "ego-alien." A therapist with a rigidly programmed set of behaviors to present during therapy will probably show little change across different clients, nor should any change be anticipated.

Use of the therapist leadership dimension is not without precedent. In many ways it is similar to the older concept of directive versus non-directive counseling. The

main difference is that the latter emphasizes a technique to be employed by the therapist--a way of acting toward the client. Leadership refers to a much more general notion, encompassing more of the therapist's personality than just his training in the specifics of conducting therapy. It emphasizes the role of the therapist in interacting with the client. This does, of course, include the older dimension--it also goes beyond a focus on technique alone. Its continuing relation to older concepts does bear testimony to its significance for all therapy though. Jesse Gordon (1957), for instance, has pointed out that the relationship dimension represents a basic split among schools of psychotherapy.

Ashby, Ford, Guerney, and Snyder (1957) have organized a number of studies using the leadership dimension, and published them in the form of a monograph. They trained ten therapists in both a leading and a reflective type of therapy. Interestingly, while these therapists could learn either technique, their learning experiences did not necessarily take precedence over what they felt to be best, so that four of their ten therapists did not remain within the orientation that the experimental design called for. These authors found that clients could relate satisfactorily not only to friendly, non-threatening therapists, but also to authoritarian ones who could engender confidence. The therapists, 90% of whom favored the more leading therapy,

consistently reported the clients more improved in this more interpretive therapy. In the leading therapy, the clients became more positive in their feelings toward therapy, and were also held in therapy more easily. The authors concluded that focusing on a problem caused guardedness and seeming maladjustment, which they felt was only temporary.

The use of the leadership dimension raises very important questions in terms of the personality of the therapist and the type of techniques he uses in therapy--either because he is more comfortable with them, prefers them, was taught them, or believes them to be more effective. These questions, along with the degree of congruence between the therapist's techniques and his more basic attitudes and beliefs (personality), perplex any insightful researcher in the area of psychotherapy. The fact that almost half of the therapists used in the Ashby et al. study cited above did not stay within the experimental requirements indicates that training alone does not account for the techniques employed by individual therapists. With this in mind, the therapists used in the present study were selected with due regard for their natural predilections in terms of leading or following orientations. In other words, role playing with techniques was hopefully kept to a minimum. What was sought in the design of this research was a maximally congruent, comfortable, and effective

therapist-technique unit, in order to see to which unit various subjects would best respond. This is consistent with suggestions made by Ford (1956), Snyder (1957) and others, who feel that the therapist and his method must be viewed as a single unit.

In addition, the Ashby et al. study failed to take into account the reciprocal effects of the various clients on the therapists and their styles. By including an analogue of therapist leadership for the client--namely the clients' level of general authoritarianism--the present study has remained truer to the interactional model described above.

As already mentioned, client dogmatism is seen as a reflection of the client's typical ways of responding to authority. It is in this sense that it has been used in the present study as an analogue to therapist leadership. By so doing, it was hoped that opposite sides of the same central issue would be tapped, and thus give free expression to whatever reciprocal effects might exist.

The use of the authoritarian dimension also has its precedents in the field of therapy research. When this concept was originally popularized in 1950 by Adorno et al. it first caught the attention of those doing research in social psychology and personality development. More recently, those working in the clinical aspects of psychology have begun to use this dimension. For instance, Jones (1962) found that

high scores on the California F Scale tended to see the role of the therapist as more directive and advice-giving. Jones also mentioned that he felt that the differences between high and low scoring groups had been attenuated by the inability of the F Scale to discriminate between tolerant and intolerant "liberals." In a similar vein, Wallach (1962) found that high and low scorers on the F Scale also preferred different types of therapists. Vogel (1961), using the same measure, found high scores related to authoritarian attitudes toward therapy in two different patient groups. These studies suggest that the F Scale is useful in detecting different attitudes toward therapy and therapists, but, as Jones (1962) points out, the scale is not without its critics.

Milton Rokeach (1960) has extended and purified the original notions of the Adorno et al. California group, and written about the concept of general authoritarianism, or what he refers to as dogmatism. He has developed and standardized his own Dogmatism Scale (1960) and criticized the California F Scale on the grounds that it does not adequately reflect general authoritarianism. Rokeach says that general authoritarianism is related to the relative openness or closedness of a person's belief-disbelief system. This system is an intervening variable which includes all of an individual's beliefs about the world he lives in, and which also orders and relates these beliefs, one to

another. Openness or closedness depends upon the person's ability to "receive, evaluate, and act on relevant information received from the outside on its own merits, unencumbered by irrelevant factors in the situation arising from within the person or from the outside." (Rokeach, 1960, p. 57) The more closed this belief system is, the more it approximates a carefully orchestrated defense system designed to "shield a vulnerable mind." (p. 70) Rokeach thus compares the extremely closed cognitive mind with the classical notion of the rigidly defended neurotic individual.

Because of its newness, this scale has not yet been extensively used in clinical work. Several early findings have been published however, which bear directly on psychotherapy. Rokeach himself (1960) reports data to indicate that high dogmatic subjects are less efficient at problem solving. Further, Powell (1962) reported that high dogmatic subjects were more subject to impression by source credibility than were low scoring subjects. This tends to support an hypothesis of Rokeach's to the effect that high dogmatic people tend to confuse source and message, rather than evaluate both on their own merits, especially when authorities are seen as the source of the message. Finally, Plant, Telford and Thomas (1965) compared high and low dogmatic persons in terms of their patterns on a standard personality inventory. These authors characterized the high

matic group as impulsive, defensive and stereotyped in their thinking. These findings, together with those from the California Scale, suggest that subjects or clients who differ along the authoritarian dimension will react quite differently to therapists who differ on the leadership dimension.

Another relevant dimension within the psychotherapeutic relationship (and one that will be included in the present study) is that of anxiety. This includes anxiety both as it arises as a symptomatic manifestation of the client's problem, and as it arises and is dealt with within the context of the leadership-authoritarian relationship per se. In the latter sense, it is a good index of the client's subjective reaction to the relationship. Further, to the extent that the client's problems have caused him anxiety, it assesses the outcome of therapy in terms of its effectivenes in reducing that anxiety.

Having established the general area to be studied, it is now necessary to discuss briefly how the area will be approached. In this regard there are two relatively innovative concepts which must be introduced and expanded. These are the adoption of a "problems in living" model, and the use of an analogue design, both of which are basic to the present study. These two notions are also somewhat related in that the adoption of this model facilitates,

at both the theoretical and practical levels, the applicability of the design.

A most important contribution to the field of psychotherapy within the last decade has been Thomas Szasz' suggestion of a "problems in living" approach to psychotherapy. Szasz tells us (1960, 1961) that the old notion of mental illness has outlived whatever usefulness it may have had. It is time to recognize that maladjustment is defined in social, legal and statistical terms, and the treatment of it by medical means alone is misleading and ineffective. The logical solution, according to Szasz' point of view, is to re-orient our thinking in terms of a "problems in living" paradigm, and abandon the outdated myth of mental illness. This view is consistent with the present author's, and is intrinsic to the design of this research.

An excellent paper by Guerney and Stollak (1965) concerns itself with the application of a "problems in living" approach to psychotherapy research. They begin by summarizing the rationale of the approach:

> All individuals have intra- and interpersonal problems. . . . Such problems are dynamic and changing rather than structurally fixed and static. . . . All of us are continually engaged in the process of solving intra- and interpersonal problems. . . . There is no hard and fast line separating neurotic from normal. Rather, there are patterns of more or less success in solving these problems. . . . The person usually regarded as neurotic may be viewed as someone who habitually solves a great many such problems somewhat less well than will

> the majority of his people; or he may solve only a few very important problems at a particular point in time far less well than the majority of his contemporaries. Such people may be the ones who have the most to gain from psychotherapeutic procedures. But all people probably can benefit somewhat from some type of psychotherapeutic assistance at any time. (p. 582)

The authors then go on to state a number of heuristic advantages to the adoption of such a rationale in research. They mention: 1) By reformulating our research questions along these lines, we will bring our work more closely in line with the mainstream of general psychology, rather than restricting it to a particular subgroup of "sick" subjects, 2) On an operational level, it will allow a much wider application of experimental procedures, for the subject pool of the researcher is greatly enlarged when he is not restricted to the use of patients of this or that diagnostic category, and 3) The researcher will be more free to experimentally manipulate his subjects, governed only by the ethics of dealing with human subjects rather than having to consider the needs and prognoses of identified patients. By extending the use of normal subjects as clients, the present research, using an analogue design, hopes to take advantage of all the above possibilities.

It is apparent that Guerney and Stollak are suggesting that research proceed with a theoretical reformulation in keeping with the ideas developed by Szasz. Several studies on psychotherapy, employing the experimental analogue

design, have actually appeared within the last few years, and have been reported by Cowen (1961), Gordon (1957), Kanfer and Marston (1964), Levison (1961) and others.

As Cowen (1961) discusses the analogue design, it is a type of research in which the experimenter in some way simulates the behavior of a therapist in the process of giving therapy, while the subject is brought through some means to feel distress or a symptom comparable to that which a client might feel. It is also possible to use the anxiety generated by normal daily problems, although this may not have reached proportions great enough to motivate the subject to seek help on his own. It is in this sense that the adoption of a "problems in living" model relates to the analogue design--since the major tenet of this model is the basic similarity of problems across all persons, almost anyone becomes eligible as a research subject. However, Zytowski (1966), after having reviewed many of the analogue studies, concluded that those experiments which utilized already existing anxiety, rather than inducing it experimentally, less frequently obtained significant results. This seems to suggest that while most people may have problems, the anxiety generated may not be sufficient to make a particular person amenable to therapeutic intervention.

Nevertheless, the present study will draw upon both the "problems in living" model and the analogue design. The examination of real problems actually being experienced by

the subject is undoubtedly closer to actual therapy conditions than could be any artificial distress induced by the experimenter. Further, at least one of the dependent measures has been designed to tap a specific problem area, independent of the anxiety level of the subject. This, together with the inclusion of an anxiety measure, should help clarify the point Zytowski (1966) raises.

While the main focus of the present research is the authoritarian component within the psychotherapeutic relationship, there are other factors which must be considered, and which also affect the relationship. As is customary, some of these have been controlled for in the design of the study, and some have been allowed to vary randomly.

Among the client variables which were controlled are age, sex, education and intelligence. These are frequently controlled variables in psychological research, and it is obvious that they might directly confound any attempt to isolate relevant effects within the relationship. Age and intelligence were indirectly controlled by means of the population from which the sample was drawn--an undergraduate college group. Sex has been identified as a significant component in the therapeutic relationship by Parker (1967) and Currier (1964) as well as others. Especially in view of the main focus of this study--the authority aspect--it was deemed imperative that sex be controlled for.

In addition, whether or not the subject was presently being counseled was seen as an important variable to be controlled, for obvious reasons. Since actual problems were to be used in this study, it would have been impossible to evaluate the effects of the experimental treatment if it took place within the context of a much more extensive therapy program.

Finally, the experience of the therapists was seen as a mandatory control factor. The pioneer work of Fiedler (1950a, 1951a) and innumerable others requires such controls in any psychotherapy research.

The primary uncontrolled variable in the present study is the type of problem presented by the subjects, and its objective seriousness. This warrants some discussion. At a theoretical level, one of the most basic assumptions of the model used here is the similarity across individuals of their "problems in living." This rationale is well presented by Guerney and Stollak (1965) in the sections cited and quoted above. To classify persons according to type of problem--in short, to diagnose--would be inconsistent with the model chosen. Further, there seems to be no empirical justification for questioning this rationale at the present time. On the contrary, Parloff (1961) found no correlation between initial patient evaluations and subsequent measures of the quality of the therapeutic relationship in his group of neurotic patients.

In addition, the nature of the population from which the sample was drawn probably exercised some indirect control over the nature and seriousness of the problems presented. To have further controlled this would have required impractical demands in terms of qualified staff and numbers of subjects to be screened. At some later time this additional control may seem justifiable.

To recapitulate, the present study represents an exploration of an interactionary conception of psychotherapy. The salient aspects of the relationship which were focused on are the degree of leadership shown by the therapist, and its analogue, the client's typical ways of relating to authority. The adoption of a "problems in living" model facilitated the use of normal subject in an analogue design, which utilized both outcome and process measures in attempting to evaluate the therapeutic relationship.

HYPOTHESES

The following hypotheses are examined:

1) Both the client's and the therapist's behavior will vary as a function of the particular combination of the type of therapist the client encounters (leading or following) and the type of client he is (high or low dogmatic). In particular, it is hypothesized that the therapist will tend to show more or less leadership depending upon the client he sees, and that the client will tend to offer more or fewer solutions to his problem (take the lead or not take the lead) depending upon the therapist he sees.

2) The client's perception of the seriousness of his problem will vary as a function of the particular type of therapy he encounters (leading or following) and the type of client he is (high or low dogmatic). That is to say, it is predicted that in the analysis of the outcome data there will be a significant therapist by client interaction.

3) Similarly, it is predicted that change in the client's anxiety level will vary as a function of the particular therapist and client combination.

METHOD

Sample

The subjects used in this study were undergraduate males at the University of Florida, enrolled in one of two introductory level courses in psychology. Because the subjects were to be screened by means of the Rokeach Dogmatism Scale (1960), copies of this scale were handed out in class after a brief announcement calling for experimental subjects. In all, 122 copies of the scale were given to the members of the two classes. Of these, 99 were returned to the author, who then scored them. Either because they were incorrectly filled out, or because the respondent lacked a convenient means of being contacted, nine of these were eliminated. From the final subject pool of 90 subjects, the author contacted the 15 highest and 15 lowest scorers, when this was possible. Several people could never be reached, two declined participation when the outline of the experiment was presented to them and one person, who was already being seen at the University Counseling center, decided, with the author's agreement, that it might be best for him not to participate. When a person could not be reached, or declined participation, the next higher (or lower) person in the pool was called. All of the subjects

(30 in total) were contacted by telephone, and given the same information. This information is presented verbatim in Appendix A.

The two therapists used were clinical psychology graduate students at the University of Florida, and were matched in experience. Approximately 20 students were considered, and two were finally chosen on the basis of their demonstrated propensity to be more, or to be less, active in the conduct of therapy. Three faculty clinicians, who had some knowledge of the students in either a teaching or supervisory capacity, were consulted in making the final selection. The control group interviewer was chosen from a pool of experimental psychology students so that his age, sex and educational level was in keeping with the two therapists.

Measures

As stated above, the "clients" were selected by means of the Rokeach Dogmatism Scale. This scale is presented in full, and discussed in terms of reliability and validity in Rokeach's Open and Closed Mind (1960). He reports a range of reliabilities of from .68 to .93 for Form E of the scale. Among the validity studies reported is one concurrent measure using groups of high and low dogmatic subjects, identified as such by fellow students, and which were differentiated at a significant level by the scale.

Frequency counts obtained by means of direct observation were the measures used for testing Hypothesis I. The observers used were both graduate students in clinical psychology, presumably with some skill in observation of a therapy situation. They recorded frequency counts of both the leading and following behaviors of the therapists as well as the direction-seeking and solution-offering behaviors of the clients as observed through a one-way mirror. The criteria used for identifying leading and following behaviors were originally described by Ashby et al. (1957), and are presented below. The client behaviors observed are more or less self-explanatory; any active effort to seek advice or direction from the therapist in achieving mastery over his problem was scored as direction-seeking. Conversely, any statement to the effect that the client had spontaneously produced a tentative solution was scored as solution-offering. This straightforward approach to operationalizing behaviors observed in therapy follows the general suggestions of Glad (1959).

An instrument developed by the author (Blumberg, 1968) was used in testing Hypothesis II. This instrument, known as the Problem Pathological Potential Scale (PPPS) has as its aim the assessment of the extent to which the client sees his problem as being serious, as presenting real difficulties in overcoming it, as having the potential to seriously disrupt the client's daily routine, etc. (See

Appendix B for the complete scale.) To the extent that this problem is perceived as being insurmountable, severely disabling and insoluble, it is assumed to take on pathological proportions. The scale consists of eight items which are alternated in terms of pathology, to avoid the misleading effects of response set in producing false positives and false negatives. Each item is quantified to yield a score ranging from 1 to 10, so that the total score on the scale ranges from 8 to 80, with a high score indicating a more serious problem. Quantification of the scale is accomplished by means of a line graph for each of the items, upon which the client places a check to indicate the value of his response between two extremes. It is scored by placing a grid over this line and reading off equal intervals.

In a pilot study conducted during the summer of 1967 at the University of Florida, the reliability (test-retest) of this scale was found to be .957 with a half-hour interval (N=24), and .901 with a one-week interval (N=22). While no formal validity measure has been obtained, the scale has considerable face validity. In addition, the items were chosen to reflect criteria for maladjustment commonly held by clinical theorists of various persuasions. In this sense, it possesses some degree of construct validity as well.

The Zuckerman Affect Adjective Check List (AACL) was used in testing Hypothesis III. This scale was chosen in part because of its ability to detect short-term variations such as might be reasonably expected in an experiment of this design. Zuckerman (1960) reports a split-half reliability of .85 with instructions to record immediate feelings. With this same set in mind, a validity study was devised wherein the scale was administered to college students in an elementary psychology class on both exam and non-exam days. The instrument was able to distinguish between days at a significant level.

Finally, two scales were administered to the two therapists used in this study to augment the information already available as to their natural predilections and orientations in therapy. These scales were the Strong Vocational Interest Blank for Men (Strong, 1938) and Berger's Acceptance of Self and Others Scale (Berger, 1952). The former is discussed by Strong (1943), who reports reliabilities in the range .73-.94 using 285 college seniors. The latter is actually two scales in one, designed to tap basic positive attitudes toward both the self and others. It is discussed by Berger (1952), who reports split-half reliabilities of .894 or better for the self-acceptance subscale, and .776-.884 for the acceptance of others. With respect to validity, the Pearson product moment correlations with essay-type self-descriptions of students'

ttitudes were .897 for self acceptance, and .727 for acceptance of others. The scale is also discussed by Shaw and Wright (1967), who laud its rather thorough standardization.

Procedure

After the potential subjects had been selected by means of the Dogmatism Scale, they were contacted by telephone, and asked if they would like to participate in the study. Each was told that he would be required to come into the counseling center with a personal problem that he might be asked to discuss with a professional person, that he would be asked to evaluate this problem on some questionnaires, and that the total procedure would require two sessions. (See Appendix A for complete instructions to the subjects.) When the subjects arrived at the counseling center, they were met individually by the author and given the PPPS and the AACL to fill out. They were then brought in to see one of the two therapists or the control group interviewer, according to the group to which they had been previously assigned. An equal number (five) of both high and low dogmatic subjects had been randomly assigned to the three experimental groups (leading, following and no-therapy control) before this first session. Immediately following the one-half hour-interview, the subjects were again given the PPPS and AACL by the author.

One week later, all subjects were again given the PPPS and a subjective questionnaire asking them to evaluate their reactions to the total experimental situation (see Appendix D).

The two therapists were selected according to their supervisors' or professors' impressions as to a demonstrated predilection for leading or following behaviors in therapy. To accomplish this, the supervisors and professors were originally informed of the experimental requirements and then asked if they could suggest two practicum or intern students who seemed to best fit the bill. The author then presented these suggestions to the three clinical members who supervised this research, and together agreed on the final selection. To further reinforce their natural predilections for leading or following behaviors, the author carefully reviewed with the therapists what was desired in terms of experimental design--that they be a leader or follower, respectively. In addition, two pilot interviews were allowed each therapist as training sessions. After these sessions, the author prompted the therapists on what would have been more desirable behaviors from the experimental point of view, i.e., what would have been the leading or following thing to do, etc. As previously mentioned, each therapist was given the Strong and Berger scales, and asked about his own preferred and usual ways of doing therapy. Both of the therapists were males, of

approximately equal experience--one was working at the internship level in counseling psychology; the other was at the practicum level, but with one year's professional experience in a counselling position.

In the leading treatment (LT) group, the therapist discussed the client's problem with him as if he (the therapist) were an expert and authority on such problem solving. He offered suggestions, gave advice, reassured, admonished, gave praise when he felt the client deserving of it, etc. The techniques he used may well be described as "directive." This situation has been described by Ashby et al. (1957) as:

> . . . [being] composed of directive leads, interpretations, directive structuring, approval, encouragement, suggestion, advice, information giving, and persuasion. . . . The therapist attempts to create a warm, accepting, understanding non-critical psychological atmosphere; to contrast the client's report of his situation and difficulties with an objective reality as the therapist deduces it. . . .

On the other hand, no such representation as authority was offered in the following treatment (FT) group--the therapist was friendly, supportive, neutral, accepting of whatever suggestions or behavior was given by the client, etc. The techniques relied upon here for conducting the interview would be aptly described as "non-directive" or "reflective." The above authors describe this situation as follows:

> This family of responses included restatement of content, reflection of feeling, non-directive leads, and non-directive structuring responses. This therapy was built largely on the Rogerian approach. (p. 6)

The primary purpose of the control group was to provide an equal period of discussion and contact with another person, but to avoid any consideration or discussion of the subject's problem itself. This was to determine the effects of simply being with another person in the experimental situation versus actually dealing with a problem in the controlled conditions designed for this study. Consequently, the neutral topic of "Highway Safety" was introduced by the control group interviewer, and was discussed for one-half hour with the control subjects. It was planned in advance that if the subject tried to alter the topic and begin discussing his problem, the interviewer would point out that this phase of the experiment called for a discussion of highway safety, and that the topic had to be adhered to. The interviewer for this group was also a graduate student, but in physiological psychology. He had had the same number of years training in his specialization as the two therapists had had in theirs. It should be noted here that the assignment of a discussion topic by the interviewer, and its enforcement by him, made this group closer in some ways to the LT group than to the FT group. Such confounding was unavoidable in ensuring a no-therapy control group,

i.e., a group in which the subject's particular problem would not be dealt with in any direct way.

Testing Hypothesis I involved the use of frequency counts, and these were considered as factors themselves in the analysis of the resultant data (therapy X client X observers). This analysis applied only to the two therapy groups, and not to the control group. The procedure for testing Hypothesis II was to take the change scores on the PPPS for the one-half hour and one-week intervals, and analyze these data in a three-factor analysis of variance design (therapy X client X test-retest). Similarly, the procedure for testing the third hypothesis was to take the change scores on the AACL over one-half hour, and analyze these data in a two-factor design (therapy X client).

To facilitate and augment data collection, the author observed and recorded on tape all of the experimental sessions through a one-way mirror. No attempt was made to conceal either the mirror or the microphone from the subjects, and, if they asked, the entire recording procedure was explained to them. In addition, as mentioned, two observers were also present in the observation room during the two treatment groups, but not during the control group sessions. Finally, both therapists were asked to subjectively evaluate their degree of liking for the subject, as well as their estimate as

to how valuable the session had been, immediately after seeing each subject.

RESULTS

Pretreatment Findings

The reader will recall that the final subject pool consisted of 90 college males enrolled in one of two introductory psychology classes at the University of Florida. These students had been selected for the study on the basis of their scores on the Rokeach Dogmatism Scale. The scores obtained ranged from a high of 190 to a low of 82, with the high scores indicating high dogmatic or closed-minded orientations. This array of scores yielded a mean of 135.98, with a standard deviation of 18.00, which is consistent with the data presented by Rokeach (1960).

When the 30 subjects who participated in the study had been selected, they were randomly assigned to one of three groups--leading, following, and control, for a total of 10 people in each group (five high and five low dogmatic subjects). To insure that a random sort with such small numbers had not produced a biased sample in one or more of the groups, dogmatism scale scores were compared across groups. Table 1 below presents the means of these groups, the differences between each of these means and the grand

mean, and the equivalent of these differences in standard deviation units.

Table 1

Summary of pretreatment findings on the Rokeach Dogmatism Scale

		Leading Group	Following Group	Control Group
High Dogmatism	Mean	168.2	163.6	161.0
	Difference	4.0	.66	3.26
	SD	.36	.06	.34
Low Dogmatism	Mean	105.4	94.2	110.6
	Difference	2.0	9.2	7.2
	SD	.26	.73	.57

On the other hand, it was vital to the study that the high and low dogmatism subjects differed significantly. Examination of these data indicated that the mean of the high dogmatic group was 164.3, while the mean for the low group was 103.4. The means for the two groups were thus separated by 60.9 points, or 3.38 standard deviations, indicating a clear difference between them.

Further, in order to justify the use of the analysis of variance, rather than an analysis of covariance, or some other design, it was important to demonstrate that the high and low dogmatic groups did not differ on their initial scores on either the PPPS or the AACL. The high dogmatic subjects obtained a mean score of 40.33 on the initial administration of the PPPS, while the low dogmatic people

obtained a mean of 37.00. The grand mean of this distribution was 38.66, and the standard deviation was 8.00. Since the difference between the high and low group means and the grand mean is only 1.67, they differ from the grand mean by only .21 standard deviations. Similarly, the mean of the high dogmatic subjects on the initial administration of the AACL was 8.94, while the low dogmatic subjects scored a mean of 7.35. The grand mean of the distribution was 8.17, with a standard deviation of 2.64. Since the difference between the group means and the grand mean is only .82, they differ from the grand mean by .30 standard deviations.

Examination of the data collected on both of the therapists used in the study proved most interesting. The leading therapist scored a total of 257 on the Berger Acceptance of Self and Other Scale--143 for Self; 114 for Other. (The number of items for the two scales are not equal, so the scores are not directly comparable.) On the other hand, the following therapist scored a total of 291 (164 Self; 127 Other). The result is thus a small but consistent tendency for the following therapist to show greater acceptance of both Self and Others.

The Vocational Interest Blank profiles differed somewhat for the two therapists. Looking only at the highest scoring professions (those in the A range of interest compatibility) it was found that the leading therapist

saw himself as closest to mathematicians, lawyers, and computer programmers. On the other hand, the following therapist saw himself as closest to psychologists, social workers, librarians, music performers, music teachers, and author-journalists.

Posttreatment Findings

Hypothesis I was tested by means of two separate analyses. The first of these examined the ratio of leading responses to total responses (leading or following) observed for each of the two therapists by each of the two observers. This resulted in a three-factor analysis of variance, with therapy (leading and following), dogmatism (high and low), and observers (first and second) as factors. Proportions were used as a means of statistically controlling for total productivity of the two observers, thus ruling out the possible contamination due to one observer being more active in identifying responses of both types. Using proportions also had the practical advantage of eliminating the need for separate analyses of the two types of responses observed. Table 2 provides a summary of this analysis.

By far the strongest finding, both across observers and across levels of "client" dogmatism, was that the proportion of leading responses observed was far greater for the leading therapist than for the following therapist

(see Appendix E for table giving total proportions of leading responses by therapists). Interestingly, observer agreement was not nearly so high where following therapy was concerned, giving rise to a significant observer effect, which was part of an even stronger interaction between therapy and observers. Figure 1 graphically presents the nature of this interaction. This graph, plotted in terms of total proportions for all subjects, indicates that while the two observers agreed very closely on leading therapeutic behavior, there was more disagreement in the following condition. It also indicates that despite this effect, neither observer had any difficulty seeing more leading responses in the leading therapy.

Table 2

Analysis of variance for therapist leading responses

Source	Sum of Squares	df	Mean Square	F
Between	4.33	23		
Therapy	4.00	1	4.00	242.42*
Dogmatism	0.00	1	0.00	---
Therapy X Dogmatism	0.00	1	0.00	---
Error	.33	20	.0165	
Within	.39	24		
Observers	.07	1	.07	10.77*
Therapy X Observers	.18	1	.18	27.69*
Dogmatism X Observers	.01	1	.01	1.54
Therapy X Observers X Dogmatism	0.00	1	0.00	---
Error	.13	20	.0065	

* $p < .01$

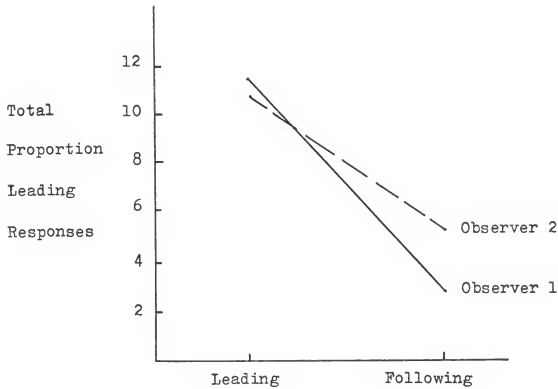

Figure 1. Therapy X observer interaction for therapist leading behaviors.

The second analysis performed in testing Hypothesis I was on the proportion of observed solution offering responses by the subjects. The format of this analysis was identical to the preceding--only the content of the observations differed. Table 3 presents a summary of this analysis.

Table 3

Analysis of variance for client solution offering

Source	Sum of Squares	df	Mean Square	F
Between	4.16	23		
Therapy	.50	1	.50	2.78*
Dogmatism	.04	1	.04	---
Therapy X Dogmatism	.05	1	.05	---
Error	3.57	20	.18	
Within	1.33	24		
Observers	.03	1	.03	---
Therapy X Observers	.11	1	.11	2.20*
Dogmatism X Observers	.02	1	.02	---
Therapy X Dogmatism X Observers	.14	1	.14	2.80*
Error	1.03	20	.05	

* $p < .25$

Here too, the predicted therapy X dogmatism interaction failed to appear. It must be noted also, that those findings which appeared were not significant. Once again there is a therapy effect with the leading therapy condition associated with the lowest proportion of solution offering on the part of the clients. (See Appendix F for complete table of total proportions of solution offering by clients.)

A therapy X observer interaction also appeared again, but this time both the main effect and two-way interaction were embodied in a complex three-factor interaction. This is presented graphically in Figure 2. Once again this graph is plotted in terms of the total proportions across all subjects in each condition. It can be seen that in the leading therapy, observers tend to agree more when the relationship includes a high dogmatism client. Conversely, their observations diverge more with a low dogmatism client. Further, it can be seen that in the following therapy, the observers tend not to show a discrepancy dependent upon the level of dogmatism, and also that there is some slight tendency for more solution offering to be observed in this therapy condition across the other factors, especially with low dogmatic subjects.

Hypothesis II was tested by means of the change in scores obtained on the PPPS at one-half hour and one week intervals. Analysis of these data was accomplished through the application of a three-factor analysis of variance (3 X 2 X 2) with treatment (leading, following and control), dogmatism (high and low) and time of test (immediate and one week follow-up) as factors. Table 4 provides a summary of this analysis.

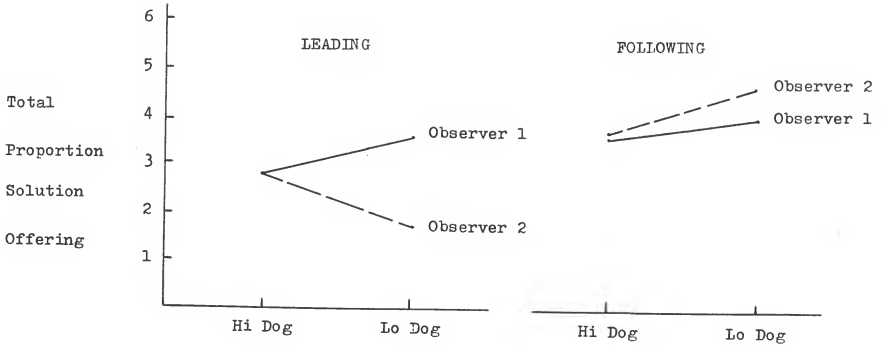

Figure 2. Therapy X dogmatism X observer interaction for client solution offering.

Table 4

Analysis of variance for PPPS change scores--immediate and delayed test

Source	Sum of Squares	df	Mean Square	F
Between	1657.40	29		
Therapy	42.70	2	21.35	---
Dogmatism	2.40	1	2.40	---
Therapy X Dogmatism	181.30	2	90.65	1.52*
Error	1431.00	24	59.63	
Within	493.00	30		
Time of test	48.60	1	48.60	2.94**
Therapy X Time	7.30	2	3.65	---
Dogmatism X Time	.60	1	.60	---
Therapy X Dogmatism X Time	39.90	2	19.95	1.21
Error	396.60	24	16.53	

* $p < .25$
** $p < .10$

As predicted, a therapy X dogmatism trend did appear, but was not significant. Interestingly, the time of test main effect came out at a higher level of probability with a greater positive (diminution of problem seriousness) change recorded one week after the treatment (see Appendix G for complete table of change scores and means). Inspection of the individual change scores revealed, however, that while the mean of the retest scores was higher, the variation was considerably greater also. Since the therapy X dogmatism interaction had been tested across both levels of the test factor, it was concluded that the greater variation in the retest scores had partially masked the effect predicted in Hypothesis II. Consequently, a post hoc analysis was conducted using only the change scores obtained from immediately

before to just after the treatment session. Table 5 presents a summary of this post hoc analysis.

Table 5

Post hoc analysis of PPPS change scores

Source	Sum of Squares	df	Mean Square	F
Therapy	7.8	2	3.9	---
Dogmatism	2.7	1	2.7	---
Therapy X Dogmatism	177.8	2	88.9	3.57*
Error Within	598.00	24	24.9	

* $p < .05$

As indicated, the therapy X dogmatism interaction tested significant at the .05 level in this post hoc analysis. This interaction is presented in graphic form in Figure 3, which clearly shows that the high dogmatic subjects showed the greatest positive change with a leading therapist, and showed a negative change with a following therapist. Just the opposite occurs with the low dogmatic subjects. Both high and low dogmatic subjects reported negligible change in the control treatment, although the high dogmatic people tended to report a very slight positive change. An interesting finding was that the greatest positive change of all was reported in the low dogmatic group receiving the following treatment. In addition, this was the only group in which no one reported a negative change.

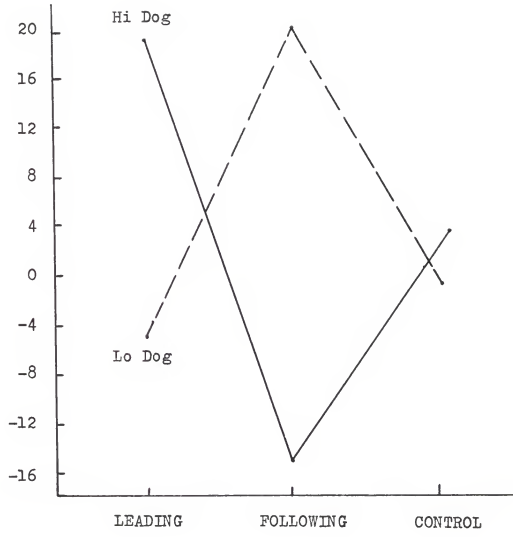

Figure 3. Therapy X dogmatism interaction for PPPS change scores.

Hypothesis III was tested by means of the change scores over the one-half-hour treatment session on the AACL. Analysis of these data was accomplished by means of a two-factor analysis of variance with therapy (leading, following, and control) and client dogmatism (high and low) as factors. Table 6 provides a summary of that analysis.

Table 6

Analysis of variance for AACL change scores

Source	Sum of Squares	df	Mean Square	F
Therapy	40.3	2	20.2	2.38*
Dogmatism	0.0	1	0.0	---
Therapy X Dogmatism	3.2	2	1.6	---
Error Within	204.4	24	8.5	---

* $p < .25$

Contrary to the prediction made, the therapy X dogmatism interaction failed to reach a significant level in this analysis. It will be noted that there is a non-significant main effect in the data, indicating that across both high and low dogmatic groups there is a tendency for the leading therapist to produce the greatest positive change (reduction in anxiety) among the subjects. (See Figure 4 for graphic illustration, and Appendix H for complete table of change scores and means.)

Examination of the subjective data collected from both the therapists and the clients did not reveal any strong

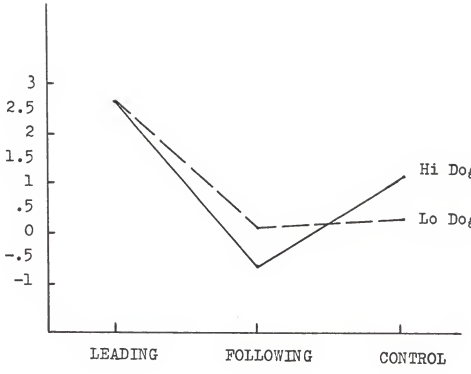

Figure 4. Plot of AACL change scores.

trends, although many of the individual comments made by subjects were enlightening (see discussion section). It was interesting that some 87% of the high dogmatism subjects seen by the Leading therapist liked him very much, while 60% of the low dogmatism people liked the Following therapist, and only 50% of the other two groups liked the therapist they saw. This is especially interesting in view of the fact that the Following therapist liked 33% of the high dogmatic people he saw, and only liked 17% of the low dogmatic subjects. In the same vein, the Following therapist saw the session as not at all valuable for 87% of his low dogmatic clients, and only 33% of his high dogmatic people. Just the reverse was true for the Leading therapist, who felt that the experience was not at all valuable for 67% of his high dogmatic subjects, and for only 17% of his low dogmatic interviewees.

DISCUSSION

This research explored, in several different ways, what Moos and Clemes (1967) have called the "patient-therapist system." Hypotheses concerning both process and outcome measures were generated from a point of view about psychotherapy and counseling which might well be labeled interactionary. This view, which is more fully developed in the introduction to this paper, has as its major assumptions the following: Both the process and ultimate outcome of therapy are dependent upon the therapist, the client and the emergent behaviors induced by the interaction between these two; Client and therapist behaviors, in the process of therapy, and their attitudes toward the outcome of therapy, will vary as a function of particular therapist-client combinations; Therapist leadership, and its analogue, the client's typical ways of relating to authority, are crucial components of the therapeutic relationship because of the conditions under which clients typically seek such an encounter, i.e., when they are in distress and need "expert" advice and help.

The results of this study confirm certain of the hypotheses derived from these assumptions and fail to confirm others. The non-confirming data tend, at this point,

not to weaken the assumptions made, but rather to point out additional complexities to be considered in subsequent research. An example of this is the finding that fairly sophisticated observers differ among themselves as to what constitutes leadership, and, to an even greater degree, differ as to what are solution-offering and direction-seeking responses on the part of clients. This latter finding, for instance, raises the interesting speculation that therapy-wise observers may tend to be overly influenced by the behavior of the therapist, and thereby overlook the important contributions of the client in determining the interaction. Further, the subjective data collected indicate that attitudes toward the encounter tended to be more process and outcome oriented for the therapists, and more liking-disliking oriented for the clients. In a sense this only demonstrates the well-known principle that what we are trained or interested in looking for affects what we see. However, it also adds relevant dimensions to the future study of therapy relationships. In this way the present research has broadened the perspective of the concepts originally proposed, and demonstrated some of the difficulties involved in approaching them empirically.

The presence of a significant interaction between the type of therapy and the level of client dogmatism, in terms of change scores on the PPPS, lends considerable support to the rationale of this study. Much of the

multivariate work done which has indicated an interaction between client and therapist has demonstrated this in terms of process data, with little mention of how either the client or the therapist saw the ultimate purpose, or outcome, of the therapeutic encounter. Such work has been reported in the past by Moos and Clemes, 1967, Truax, 1966, Van Der Veen, 1965, and others. The present finding demonstrates that the effects of the interaction extend beyond the actual process measures, and can and do influence the client's perception of the seriousness of his problem. Further, the lack of change in the PPPS scores for the control group solidifies the finding and attributes it directly to the counselor's attempts at therapeutic intervention, eliminating the possibility that this change is a function of social contact alone.

Several comments must be made regarding this finding. First, there are differences between what these subjects, knowingly participating in an experiment, must have experienced, and what actual clients seeking help must experience. This is the toll of authenticity paid by any analogue study, or, for that matter, any laboratory study as compared to actual field work. The entire question of the subject's real involvement is paramount here. While the instructions asked each subject to bring in a problem with which he was really concerned, there was no further control exercised over this variable. Certainly further research is called for where the degree of involvement can

be ascertained. However, there were certain post hoc checks which could offer suggestions as to how involved the subject was with the problem he brought in. These included the nature of the problem itself, the initial score on the PPPS, which provided a very subjective estimate of problem seriousness, and, in some cases, the comments made by the subjects at the conclusion of the experiment.

The range of problems dealt with in this study went from the very frequent vocational or academic concerns, to marital discord and the threat of alcoholism. In one case the problem caused enough concern that the subject asked if he might pursue it further at the counseling center, beyond the extent of this study. One week later however, this same subject felt that he had been able to look more carefully at his difficulty during that week, and now felt that he would be able to handle it on his own. Even with such exceptions, the author often felt that the subjects were considerably less concerned about their problem than actual clients would be. This probably contributed to the variance seen in the outcome measures to a great extent. A future study might be enlarged to the point where uninvolved subjects, as judged by a panel of experienced clinicians, could be eliminated.

As mentioned above, the initial scores on the outcome measures did not differ significantly for the high or low dogmatic subjects. In a sense, this insures some

measure of subjective equivalence between problems. The very subjectivity of the measure builds in the possibility of tremendous variance however, for what to one person may seem reasonably problematic, may to another seem a trifle, or a disaster! Further study, with objective ratings of problem seriousness, would tighten control of this variable.

In addition, the post-interview comments of the subjects themselves sometimes tell rather convincingly their levels of involvement. Compare the following two comments, both made by low dogmatic scorers in the leading therapy group: "I probably need to take more of a serious interest in this problem in order to bring about any great change. I am not ready to do so at this time." The other boy seems to be writing of a different kind of experience altogether: "I see my problem from a different standpoint, i.e., it is not unique. I feel some confidence in tackling the problem now, knowing that with effort and bravado, I can overcome my intense self-awareness." It can probably be assumed that the former boy would not have presented himself in a real counseling setting--this type of client seems to be a function of the analogue design employed in the present study.

Some discussion seems necessary concerning the finding that the change in scores on the PPPS becomes much more variable after one week, while at the same time the mean change tends to increase across all subjects. It seems

likely that this finding is best explained in terms of the discussion above concerning the level of involvement. When the subject first learned that he would have to bring in a problem, it is likely that he gave considerable thought to such a problem. Such atypical focusing may well have increased his awareness and concern. At the conclusion of the treatment session, with its feeling of closure, the problem was probably restored to its former level of awareness. In the ensuing week, many events, both positive and negative, may be assumed to have beset the subject. When he was again asked to rate this problem, one week later, it is not surprising that he tended, with considerable variation across subjects (possibly due to differing degrees of involvement), to see his problem as less serious.

Such considerations aside, it is interesting to consider the import of the finding as it stands. As already mentioned, it supports rather well the model proposed for the therapeutic relationship. In addition, it extends the data on the client-therapist system from process measures to outcome measures in a consistent way. Thirdly, it spells out the nature of this relationship in two fairly broad dimensions, and indicates what combination of dimensions will probably lead to the most favorable results, in terms of client perceptions or purely subjective ratings. This would seem to be an important finding vis à vis the training of therapists and, also, the selection of therapists

where individual clients are concerned, i.e., who should see whom toward what end, etc. In this study, analysis of the empirical data and examination of the subjective data obtained combine to indicate that a favorable outcome to therapy depends upon the client, the therapist and the combination of the two in a particular unit.

Most interesting in this regard were some of the reactions and comments made by high dogmatic clients to the three treatment conditions. One is tempted to generalize from a few cases, and say that the high dogmatic people were much more demanding and rigid in reacting to the experiment. For instance, one boy who saw a leading therapist complained: "Upon leaving, I had the feeling that he should have helped more by giving some suggestions toward solving my problem. As it turned out, the help came by simple [sic] his listening: a person, outside my family, interested." Another boy, subjected to the experience of seeing a following therapist, was even more expressive. Because he so adequately gives the high dogmatic reaction, he will be quoted at length: "I had just related my problem and did not have adequate time to discuss it. I opened up to the councelor [sic] and there was not time to get much reaction. I was thoroughly frustrated, and my problem seemed worse. Discussion time or counciling [sic] time should not be strictly regulated. If the discussion is getting repetitious, no progress is being made and the councilor has other people

to see, he should tactfully make another appointment. The councilor's time should be flexible." It is rather obvious that this subject was not happy, and, further, that he was trying to structure the situation to meet his own needs and preconceptions.

High dogmatic subjects also reacted strongly to the no-therapy control group. In one case, a subject interrupted the control group interviewer and said, "I don't know who chose this topic (highway safety), but I find it very boring, and I'd much rather talk about my problem." Another boy saved his discontentment until after the session, and then quite angrily told the author that he was very frustrated at not being asked to discuss this problem he had been thinking about for several days. He seemed somewhat upset, and the author promised to see him individually at the conclusion of the experiment, to discuss his problem and see what might be done toward getting help for him. An appointment was arranged at that time. After breaking that appointment three times, the subject showed up with a rather innocuous problem in the academic-vocational area. After an hour and a half of pleasant conversation, he left, concluding that everything would work out.

In general it can be said that the low dogmatic subjects were able to accept much more readily and agreeably the conditions imposed by the experimental design. All of this has convinced the author still more strongly that the

client's level of dogmatism or general authoritarianism is a most relevant variable in the therapeutic relationship, and that it interacts most directly with what may be considered its analogue, that is, the degree of leadership demonstrated by the therapist.

The analysis of the AACL data, while non-significant, reveals a certain trend in terms of the effects of the various treatments on subject anxiety levels. Examination of the treatment means across all subjects (see Appendix H) shows that there is a tendency for the greatest reduction in anxiety to occur in the leading treatment group; the next highest occurs in the control, and the lowest of all (actually a negative change--that is, an increase in anxiety) occurs in the following treatment. The fact that the control group does register a greater positive change than one of the treatment groups suggests that this measure (AACL) is responsive in this study to some other variable than the effects of therapeutic intervention, at which it was originally aimed. Indeed, this might also explain the failure of the predicted interaction to appear.

A plausible explanation is that the check list is responsive in this study not only to the particular problem presented by the client, but also to the more immediate stress of having to participate in a rather ambiguous experimental situation. The above comments concerning the level of the subjects' involvement with their problems make this

assumption doubly tenable. To the extent that it was the ambiguity of the setting which gave rise to the anxiety tapped by the AACL, then it might be expected that the more structured and unambiguous treatments, e.g., the leading and control conditions, would lead to the greatest diminution in anxiety. Along these lines, the non-significant results obtained are consistent with the review of analogue studies by Zytowski (1966). He found that the studies using already existing anxiety less often showed significant results than did those which experimentally induced anxiety. Apparently, all people have problems which cause some anxiety, but this anxiety may not be great enough to show significant changes with treatment, or it may be overshadowed by the situational stresses involved in the treatment process itself.

A further note, directed to the large variation in the data, and the consequent failure of any of the anxiety findings to reach significance, is the greater generality of the concept of anxiety. It was for this reason that the author developed and used the highly focused and specific PPPS for the assessment of particular problems.

The process data collected have yielded a number of unexpected and interesting findings. In the main, it was the results concerning the observer factor that proved most perplexing, especially in view of the fact that this was originally conceived of as a control factor.

Concerning the proportion of leading responses by the therapists, the reader will recall that there was a very strong therapy effect, indicating rather clearly that the two therapists were, on the whole, acting quite differently in the experimental situation. In addition, however, there was a significant observer effect which combined with the therapy variable for a rather strong therapy X observer interaction. It is this interaction which is perplexing, for either of the two main effects is understandable, and, in the case of the therapy effect, quite desirable. Since the nature of the interaction is such that the observers agreed much more closely when leading therapy was concerned (see Figure 1), it would seem either that the definition of terms was faulty in this experiment, or that there is something intrinsically vague about following behaviors on the part of psychotherapists. Since both observers received the same amount of training with both types of therapy, it does not seem plausible that training differences could account for the different levels of agreement across therapy.

As stated above, the operationalization of the concepts of leading and following therapy used in this study were taken directly from Ashby et al. (1957). These authors have used this system rather succesfully, and have reported their findings in a monograph cited just above. Further, it is apparent that the concepts of leading and following are analogous to the older and widely known dichotomy between

directive and non-directive counseling techniques. In view of the fact that both observers were graduate students in clinical psychology, and had both had courses in counseling techniques, it seems unlikely that faulty specification of terms can explain the findings. The possibility of an observer bias exists, but cannot by itself explain the different levels of observer agreement across therapy types.

The most parsimonious explanation seems to be that in this study, there was something intrinsic to following behaviors which made them less identifiable to the observers. This suggests that there may be a general vagueness and ambiguity about following or non-directive behaviors, although the small number of observers used here cannot support such a general statement except as an hypothesis. Further research might explore this serendipitous finding and determine, using many more observers, if there is a general and consistent difference between rater reliabilities for leading and following behaviors.

In one rather obvious way, following therapy might well be expected to be more difficult to specify. It is a less "active" stance, and in some ways its operations approach non-behaviors, or at least, from the point of view of this study, non-verbal, and therefore non-scorable, behaviors. In a leading orientation, a verbal statement is almost a requirement whereas, in the following mode, a wink, a nod, an "Mm-hm" or a subtle facial expression will often suffice.

The presence of these additional minimal cues may add appreciably to the variance found in following behaviors.

An interesting study by Truax (1966) seems to strengthen, by analogy, the assumption that following or non-directive behaviors are elusive traits. He took excerpts from a single, successful therapy case, conducted by Rogers, and analyzed the recordings, testing to see if empathy, warmth and directiveness were consistently manifested, independent of patient behaviors. Rogers (1957, 1965) has, of course, maintained that such consistency prevails in good non-directive therapy. Truax found that Rogers responded differently to five of the nine patient behaviors studied. Moos and Clemes (1967), noting Truax' work, comment: "If there is differential responding in empathy and warmth to different content with one patient, it is but a small step to suggest that there is also differential responding in empathy and warmth to different patients." In essence, these authors are suggesting that Rogers and other leaders in non-directive counseling may actually be less consistent than they think they are. Part of their lack of awareness, and indeed, their lack of emphasis on technique, may be due to the elusive nature of the operations they employ. This possibility is consistent with the findings of the present study.

Unfortunately, the findings concerning the proportion of solution offering by clients are non-significant.

Further, all three factors studied gave rise to an interaction--a situation always difficult to understand, and made doubly uncertain by the high chance of a random occurrence in this case.

Nevertheless, it is interesting to note that the leading therapy tended to yield (at the .25 level) less solution offering than did the following therapy. This seems to be evolving as a fairly consistent finding. For instance, Frank and Sweetland (1962) found that directive therapists tend to elicit fewer statements from their clients which reflect understanding and insight into their problems. If this is a general finding, and given that spontaneous verbalization of insight is valued as a therapeutic process, then the findings tend to favor a following type of therapy, especially with low dogmatic clients.

A word must be said regarding the failure of the predicted interactions to appear, in both the therapist leadership and client solution-offering data. In addition to the above-mentioned difficulties in dealing with the elusive nature of following behaviors, which gave rise to observer differences, it is very probable that the instructions and training given to the therapists interfered with the normal process of therapy for them. For instance, Rottschafer and Renzaglia (1962), who tried to select "reflective" and "leading" therapists by direct observation,

ultimately found that their therapists were using a combination of the two styles, apparently according to the particular client they were seeing. It is noteworthy however, that their therapists were not aware that they were being chosen as one or the other. In the present study, the therapists were preselected for leading or following orientations on the basis of supervisor's or professor's ratings, but were then further instructed and trained in their orientations, and asked to be consistent in them. While this was originally planned to heighten control of the therapy variable, it apparently "controlled out" the very effect that was anticipated. The therapists did not vary as a function of clients seen, because the therapists tried hard to be as unvariable as possible.

An incidental observation made by the author during the course of the experiment supports the notion that the instructions and training given had unduly constrained the therapists in their functioning. Immediately after the first training session with the following therapist, who had just seen a low dogmatic subject, the therapist complained at his discomfort during the session, saying that the long silences and rather redundant conversation had made him feel very ill-at-ease. He continued, saying that with such a reticent subject, staying within the confines of his orientation was difficult, and made him feel quite frustrated. It was at this point that he said, with telling irony, "Whether

or not I can be following in my therapy depends a lot upon the client." Lamentably, experimental rigor could not be sacrificed at this point, for the therapists knew nothing of the aims of the research. The author simply acknowledged that this might be the case, and supported his efforts at staying within the paradigm as much as possible.

It seems apparent that if so much emphasis on how the therapists ought to act had not been built into the design, at least the following therapist would have acted in a more flexible manner. The emphasis and training that was given seems to have restricted the movement of the therapists, and overpowered an effect that might well have materialized. Further research should allow more natural variation to occur, without the constraints of instructions and training, and observe and report whatever findings evolve. The interesting comments made in this study by the following therapist highlight the importance of allowing the therapist freedom of movement in therapy, so that he does not feel constrained by any particular orientation.

Another possible, though more speculative explanation for the failure of expected interactions to appear in these data may be that there was not very much difference between therapists in terms of the pervasive personality characteristics which find expression in so many subtle and often uncontrollable ways. Certainly the numerical differences obtained on the Berger scale were not extreme, although

they did reflect a predictable variation. On the other hand, the interest form data did present quite a different picture of the two therapists, again in a way that is theoretically meaningful. Once again, additional research is needed to identify the relevant therapist traits which covary with leading and following orientations. Parker (1967), for instance, has recently used a measure of therapist dominance, and found that dominance is positively related to directive therapist verbalizations, and negatively related to non-directive statements.

Another possibility is that of an observer set or bias to see the therapist as the crucial determinant in the therapeutic relationship, as suggested earlier in the opening paragraphs of this discussion. If one looks only at the levels of probability of the findings summarized in Tables 2 and 3, regardless of the particular findings themselves, it is clear that the internal variance, and consequently, the error terms in the therapist measure (Table 2) are smaller. This gives rise, in part, to higher probability levels (.01 versus .25) for the findings reported. This smaller variation in the therapist data may reflect a tendency on the part of the observers to attend primarily to the therapist, and neglect the client and his role in determining the course of the relationship. In this regard, the reader will recall that the same observers were observing both therapist and client behaviors simultaneously. The tendency to see

the therapist as more "potent" is probably fostered by training programs in clinical psychology, in which both these observers were enrolled. Future research might use much more experienced observers, or totally naive ones, in order to achieve enough distance from the observed therapists, and ensure greater objectivity in the observations.

A number of interesting, albeit very tentative trends emerged from an examination of the subjective data collected from the subjects and therapists. The reader will recall that there was some tendency for high dogmatic subjects to like the leading therapist more than other groups liked their respective therapist. This was also true of the following therapist and the low dogmatic group. It would seem that the personality characteristics associated with either high or low dogmatism scores in part determined the subject's reaction to his counselor. Ironically, the following therapist showed a slight preference for the high dogmatic group. However, this may well be a function of the experimental restrictions placed upon him, for it will be recalled that this therapist was most stressed by the experimental situation when he was called upon to be a follower with a reticent, low dogmatic client. Not so easily explainable is the tendency for both leading and following therapists to see as not at all valuable sessions with high and low dogmatic clients, respectively--the very groups that reported in higher percentages a liking for their therapists.

It may well be that the same sense of frustration experienced by the follower with such clients caused him to feel that the session had been less valuable. On the other hand, the leading therapist may have found the high dogmatic subjects less malleable and more resistant to his leads. In any case, the discrepancies between the clients' and the therapists' subjective reports suggest an interesting possibility. It seems that to a significant degree, the therapists were "evaluating" the sessions, and reacting to them, in terms of process and predicted outcome, while the clients evaluated in terms of their degree of liking and comfort for their therapist and for the total situation. Clearly, additional research will be required to assess more fully the subjective reactions of both clients and therapists to various combinations of leadership and dogmatism levels, as well as the sets and values that are applied to quasi-therapeutic encounters by each. In its initial stages, such research might prove most fruitful by gathering anecdotal comments concerning individual reactions, such as discussed briefly above.

Throughout the course of this discussion, references have been made to the need for further research, along with suggestions as to how this future study might be revised and thereby improved. It was felt that mentioning these suggestions during the course of the discussion, as the points arose, would make for better reading and continuity of thought. In closing, however, these suggestions should not obscure the

need for cross-validation of the positive findings as they now stand. Optimally, this should be accomplished by another, unbiased, and disinterested experimenter.

SUMMARY

The present study attempted to test the primacy of the therapist-client relationship in determining both the process and outcome of therapy. A factorial psychotherapy analogue design was employed. Thirty normal college males were selected on the basis of either very high or very low scores on the Rokeach Dogmatism Scale. These subjects were randomly assigned, within a fully balanced design, to three treatment conditions: a Leading Therapy, a Following Therapy, or a No-Therapy control group. In each treatment condition, the subjects were interviewed individually for one-half hour by a different "therapist" (a graduate student in clinical psychology selected either for his tendency to pursue a leading or a following orientation in therapy). Subjects in the two treatment groups discussed a self-selected personal problem that the subject was asked to bring in with him to the session; those in the control group discussed highway safety.

Outcome data collected consisted of changes in perception of problem seriousness as measured by the Problem Pathological Potential Scale and change in anxiety as measured by the Affect adjective Check List. Process data consisted of frequency counts of leading and following behaviors

by therapists, and solution-offering and direction-seeking behaviors by clients, recorded by the same two observers. It was hypothesized that all measures would show a significant therapy X dogmatism interaction. This was supported by the problem scale data, but not for the others. Failure of the predicted interaction to occur with the anxiety check list data was discussed in terms of the unfocused nature of the feeling assessed, and its higher dependency upon the whole experimental situation rather than the specific problem presented. Failure with the process data was discussed as most probably due to the required adherence of the therapist to a particular type of therapy, which overcontrolled and prevented the interaction of therapy and dogmatism from emerging.

A most interesting serendipitous finding was a strong observer effect, showing that rater agreement was higher with the Leading Therapy observations than with the Following. This was discussed in terms of its implications for traditional conceptions of following or nondirective counseling.

APPENDICES

APPENDIX A

Telephoned instructions to subjects

Introduction of author.

"On the basis of the form you filled out for me in class about a week ago, you have been selected to take part in the rest of the experiment if you would like to. I thought I might explain it to you briefly, then have you decide if you would like to continue."

Response from subject.

"The remainder of the experiment will call for you to come in to the counseling center with a personal or interpersonal problem that you are presently experiencing. This problem can be at any level of seriousness, from roommate conflicts or vocational dilemmas, on through to very serious problems. The only thing we ask is that it be a real problem, that is, that it cause you some concern, and that it be present--going on at the present time. You will be asked to evaluate this problem on some questionnaires, and you may be asked to discuss this problem with a professional person, whom you will see for one-half hour. One week following this half-hour session you will be asked to come in again for a few minutes and fill out the questionnaires once more. You will receive two hours credit for participating, but you must agree to come in for both sessions. All that you do or say in the counseling center will of course be treated with

upmost confidentiality. If you are agreeable, I will set up an appointment schedule with you now."

Response from subject.

Arrangement of dates and times.

Reminder of dates, times and locations, and farewell.

APPENDIX B

Problem Pathological Potential Scale

Name _____

You have been asked to bring in a personal problem that you would be willing to discuss with a professional person. I would like you to think of that problem now. Imagine that you planned to seek help in a counseling center, and that you needed to really assess your problem before you could start solving it. Give me that assessment by placing a check somewhere on the lines below.

1. How serious do you feel this problem is?

   very _____ not at all

2. Will this problem be good for you in the long run, e.g., will it educate you, or make you stronger through experience, toughen you, etc.?

   very much so _____ not at all

3. Do you spend much time thinking about this problem?

   a great deal _____ none

4. Do you think many others share this problem?

   many others _____ no others

5. To what extent do you feel this problem interferes with your daily routine?

   greatly _____ not at all

6. Would you feel comfortable discussing this problem with a friend?

   very comfortable _____ very uncomfortable

7. Could this problem ever have disasterous consequences?

   very probably _____ no

8. How readily do you feel you will be able to overcome this problem?

very readily _____ never

APPENDIX C

Affect Adjective Check List for the measurement of anxiety

Name _____

The following adjectives describe ways in which people can feel--they describe various emotional states. Think about the way you feel right now. Circle those adjectives that apply to you (describe the way you feel) at this moment.

afraid	loving
calm	shaky
desperate	pleasant
cheerful	tense
fearful	secure
contented	terrified
frightened	steady
happy	upset
nervous	thoughtful
joyful	worrying
panicky	

APPENDIX D

Subjective evaluations by subjects

Name_____

Your participation in this experiment is now concluded. Please answer the remaining few questions as candidly as you can. Feel free to make additional comments where you wish to. Circle one of the alternatives.

1. Did you like the person who interviewed you?

   very much slightly not at all

2. Did you enjoy the experience of being interviewed?

   very much slightly not at all

3. Do you think the experience was valuable?

   very much slightly not at all

4. Did it help you to solve, or live better with, your problem?

   yes unsure no

5. Do you think participating in this experiment has made you more likely to seek professional help should the occasion ever arise?

   yes unsure no

Additional comments:

APPENDIX E

Table of total proportions of leading responses by therapists

	Subject		Observer 1	Observer 2	Total
LEADING	H	1	.88	.98	1.86
	I	2	1.00	1.00	2.00
		3	.92	.96	1.88
	D	4	1.00	1.00	2.00
		5	.93	.67	1.60
	O	6	1.00	.78	1.78
	G		5.73	5.39	11.12
	L	7	.95	.95	1.90
	O	8	.91	.97	1.88
		9	.94	.95	1.89
	D	10	.88	.90	1.78
		11	1.00	.83	1.83
	O	12	.95	.84	1.79
	G		5.63	5.44	11.07
FOLLOWING	H	13	.08	.38	.46
	I	14	.25	.25	.50
		15	.31	.45	.76
	D	16	.35	.47	.82
		17	.25	.47	.72
	O	18	.28	.50	.78
	G		1.52	2.52	4.04
	L	19	.19	.42	.61
	O	20	.32	.39	.71
		21	.47	.67	1.14
	D	22	0.00	.30	.30
		23	.14	.47	.61
	O	24	.32	.60	.92
	G		1.44	2.85	4.29
			14.32	16.20	

APPENDIX F

Table of total proportions of solution offering by subjects

	Subject		Observer 1	Observer 2	Total
	H	1	.50	.85	1.35
	I	2	.67	.73	1.40
		3	.88	.86	1.74
		4	.00	.00	0.00
L	D	5	.71	.33	1.04
E	O	6	.00	.00	0.00
A	G		2.76	2.77	5.53
D	L	7	.92	.63	1.55
I		8	1.00	.90	1.90
	O	9	.23	.24	.47
N		10	1.00	.00	1.00
	D	11	.00	.00	0.00
G	O	12	.40	.00	.40
	G		3.55	1.77	5.32
	H	13	.67	.69	1.36
F		14	.50	.70	1.20
	I	15	.83	.67	1.50
O		16	.50	1.00	1.50
	D	17	.33	.00	.33
L	O	18	.71	.50	1.21
L	G		3.54	3.56	7.10
O	L	19	.82	.80	1.62
W	O	20	.11	.64	.7 5
		21	.67	1.00	1.67
I	D	22	.75	.50	1.25
		23	1.00	.67	1.67
N	O	24	.67	1.00	1.67
G	G		4.02	4.61	8.63
			13.87	12.71	

APPENDIX G

Table of change scores and means on the PPPS

		Subject	Test	Retest
LEAD	HID	1	3	14
		2	0	-6
		3	4	-2
		4	14	25
		5	-2	-3
			M = 3.8	M = 5.6
	LOD	6	-2	5
		7	4	9
		8	-5	5
		9	2	-4
		10	-4	-3
			M = -1	M = 2.4
FOLLOWING	HID	11	-3	-3
		12	-11	1
		13	1	-2
		14	0	2
		15	-2	9
			M = -3	M = 1.4
	LOD	16	2	8
		17	15	5
		18	1	1
		19	0	1
		20	2	2
			M = 4	M = 3.4
CONTROL	HID	21	-1	-2
		22	7	9
		23	-4	-4
		24	-5	-8
		25	5	6
			M = .4	M = .2
	LOD	26	-1	1
		27	1	2
		28	2	5
		29	2	6
		30	-4	-4
			M = 0	M = 2

APPENDIX H

Table of change scores and means on the AACL

	Subject		HI DOG	LO DOG
LEADING	1	6	4	4
	2	7	2	1
	3	8	6	2
	4	9	-1	4
	5	10	2	2
			M = 2.6	M = 2.6
FOLLOWING	11	16	1	0
	12	17	1	5
	13	18	1	-7
	14	19	-7	2
	15	20	1	1
			M = -.6	M = .2
CONTROL	21	26	5	1
	22	27	-3	1
	23	28	3	0
	24	29	0	-1
	25	30	1	1
			M = 1.2	M = .4

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BIOGRAPHICAL SKETCH

Richard W. Blumberg was born June 23, 1942, at Flushing, New York. He was graduated from Brooklyn Technical High School in June, 1960, and received his bachelor's degree from the City College of New York in June, 1964. In September of that year, he enrolled in the Psychology Department at the University of Florida, where he received a master's degree in December, 1965. During that time he held fellowships from The United States Public Health Service and the Graduate School as well as an assistantship from the Veterans' Administration. In addition to his employment at the Coral Gables Veterans' Administration Hospital, he has worked at The Sunland Training Center in Gainesville, Florida. He is currently a Captain in the Medical Service Corps of The United States Army, and is interning in Clinical Psychology at Letterman General Hospital in San Francisco, California.

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This dissertation was prepared under the direction of the chairman of the candidate's supervisory committee and has been approved by all members of that committee. It was submitted to the Dean of the College of Arts and Sciences and to the Graduate Council, and was approved as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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